Snoqualmie Valley
Public Schools

PHYSICIAN'S ORDERS FOR MEDICATION AT SCHOOL

Return Fax #: _____ ATTN: School Nurse-_____

The following section is to be completed by the PARENT/ GUARDIAN:

Student:_____ **Date of Birth**_____ **Grade**: ____
School/Teacher:_____

I request that the principal, or a staff member designated by her/him, be permitted to dispense the physician authorized medication as described below. I also give my permission for the exchange of information between the school district staff and the health care provider listed below. I understand that the medication is to be furnished by me in its original container labeled by the pharmacy or prescriber with the name of the medication, the amount to be taken, frequency of administration, and name of health care provider. I understand that my signature below indicates my understanding that the school accepts no liability for reactions when the medication is administered in accordance with the physician's directions. This authorization is good for the current school year only.
If my child's physician or authorized prescriber authorizes the student to medicate himself/herself at school, I, the parents/guardian, shall hold harmless and indemnify the school and Snoqualmie Valley School District's officers, employees and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by the above named student.
If necessary the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed by the school nurse. I am the parent or legal guardian of the child named. According to state law no distinction will be made between prescription and over the counter medication. Therefore, A "Physician's orders for Medication at School" form must be signed by parent/guardian and physician for over-the-counter and prescription medicines.

_____ _____ _____ _____
Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

The following section is to be completed by the PHYSICIAN or AUTHORIZED PRESCRIBER:

Name of Student: _____
Reason for which medication is given: _____
Name of Medication: _____ **Strength** _____
Dosage: _____ **Scheduled times to be given/Frequency**: _____
Form of medication/ treatment:
_____Tablet/Capsule ___ Liquid ___Inhaler ____ Injection ____ Nebulizer
____Other _____
If medicine is to be given **PRN** or **WHEN NEEDED**, describe indications:
_____
Is child authorized to medicate himself/herself? ____ **YES** ____**NO**
This student may carry Asthma Inhaler/ Epipen: _____YES _____NO
If **YES**, I have instructed this student in the purpose and appropriate method or frequency of use; and student demonstrates necessary skill to use the medication and to use any device necessary to administer medication.
List restrictions and/ or significant side effects: _____
No side effects anticipated: _____ Special storage requirements: _____
Start Date: _____ Stop Date: _____/ End of School Year
For episodic/ emergency events only: _____
Date: _____ Physician or authorized prescriber's Signature: _____
Printed Physician name: _____ Phone: _____
Fax number: _____ Address: _____